

# MATUTECH, INC.

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Notice of Independent Review Decision

**DATE OF REVIEW: 03/19/07**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Aquatic therapy (97113), six units.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The physician providing this review is a chiropractor. The reviewer is National Board certified. The reviewer is a member. The reviewer has been in active practice for 20 years.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Documentation does not support the medical necessity for Aquatic Therapy (97113), six units.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Information provided:

Office notes (03/17/03 – 02/13/07)

Information provided:

Office notes (12/18/06 - 01/18/07)

Reviews (01/12/07 - 01/24/07)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is male who was picking up a sign weighing 20-25 lbs. when he felt a sharp shooting pain in his lower back. He was injured.

In March 2003, M.D., an orthopedic surgeon, evaluated the patient for back pain and bilateral lower extremity numbness and pain. *The patient had been treated with conservative management for lumbar instability and herniated nucleus pulposus (HNP) for a protracted period of time and then underwent L4-5 and L5-S1 laminectomy for stenosis in 1997, and another surgery in April 2000 that included instrumentation and lateral fusion at these levels. An old magnetic resonance imaging (MRI) of the lumbar spine (preoperative) demonstrated degenerative discs at L4-L5 and L5-S1 with degenerative spondylolisthesis at L4/L5 with mild stenosis. Recent x-rays revealed instrumentation from L4 to S1 with loose pedicle screws at L4 with halos about the screws and also at S1. The fusion mass was poorly differentiated and not healed at both levels.* Dr. felt that the patient was not a candidate for a dorsal column stimulator (DCS) or implantation of a morphine pump, that had previously been recommended by a pain management physician. He opined that the patient needed additional surgery that included hardware removal, re-instrumentation, interbody fusion, and redo lateral fusion. In November 2003, M.D., an orthopedic surgeon, opined that for the loose hardware and pseudoarthrosis, the patient would need redo surgery consisting of removal of the hardware, exploration of the fusion and redo fusion with re-instrumentation. He stated that the pain would not be eliminated after the surgery. A repeat MRI revealed significant central stenosis at L3-L4 above the instrumented L4 through S1 fusion. The stenosis was severe due to facet hypertrophy and there was a somewhat congenitally small spinal canal at L1-L2 and L2-L3. Due to MRI findings he also recommended L3-4 laminectomy/decompression.

In January 2006, D.C., recommended therapeutic exercises, ultrasound, interferential current, and massage to the lumbar spine. The therapy was denied stating that the patient had exceeded the maximum amount of care long ago and additional maneuvers were not justified. A home exercise program (HEP) was suggested. In December, D.C., requested aquatic therapy (97113) and massage (97124) for a total of six sessions. He stated that as the patient was obese, and aquatic therapy was a preferred method in order to avoid aggravation of his symptoms. He further added that there were no potential side effects of the aquatic therapy, there were studies that validated the efficacy of the treatment, the duration of the aquatic therapy did not exceed a reasonable timeframe, and the patient would need skilled intervention initially so that he would be able to perform independent or group therapy.

On January 12, 2007, the therapy was denied with the following rationale: (1) *The patient was last evaluated by Dr. complaining of acute low back pain with one week duration with no known precipitating cause. He should be re-evaluated as he might have recovered from this acute exacerbation consistent with natural history of his problem.* (2) *Patient's blood pressure was reported as 172/75, which represented at least a relative contraindication to the proposed aquatic*

*therapy, especially without cardiology clearance. (3) Dr. and Dr. indicated that the patient had pseudoarthrosis at L4-L5. This should be evaluated before proceeding with additional physical therapy (PT). (4) The patient had been treated with extensive PT, chronic pain management program (CPMP), and per Dr. the patient was non-compliant with his HEP. Additional therapy had minimal potential for restoration of function under these circumstances and was not supported by evidence-based treatment guidelines.*

On January 24, 2007, a reconsideration request for aquatic therapy was denied. Rationale: *The patient was now approximately seven years post incident. He was not working and had retired. He was unable to address HEP due to increased symptomatology. No clearly identifiable specific barriers had been submitted for a particular aggravation or exacerbation or other clearly identifiable physical barriers which warranted or supported the necessity of six sessions of aquatic therapy. No documentation had been submitted as to why the patient was unable to fall back on an HEP or home healthcare provisions afforded him in the past treatments. Due to absence of these evidences, the request was not supported as medically reasonable and necessary.*

In February 2007, M.D., a pain specialist, saw the patient in follow-up for low back pain reported as 5/10 and well-controlled with medication. He was on Vicoprofen, Ambien, and Theragesic cream. Dr. diagnosed lumbosacral arthropathy, anxiety, and depression and refilled medications.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The claimant's treating chiropractor states that he needs aquatic therapy for an exacerbation, because he was unable to do his land-based home exercises as they increased his pain. However, there is clinical documentation in the records that makes it highly improbable that this patient has ever been compliant with a prescribed home exercise program. There are two things that specifically stand out in his records, relative to this opinion. First, he gained 39 lbs, weighing 212 lbs in November 2003 and 251 lbs in December 2006. Second, there was a dramatic decrease in all of his lumbar ranges of motion between January 2006 and December 2006, even though a home exercise program had again been recommended in January. Aquatic therapy programs should be reserved for individuals who are unable to safely participate in totally land-based exercises. Non-compliance does not equate with inability.

In addition, this patient's medical records document potential contraindications to aquatic therapy. First, he has a history of coronary artery disease with subsequent placement of a stent, and in December 2006 his blood pressure was 172/75. Given this, clearance from his cardiologist should have been sought before beginning an aquatic therapy program. Second, he has a history of uncontrolled Diabetes Mellitus with peripheral neuropathy in his legs, noted

previously by the orthopedic surgeon. Diabetes Mellitus causes an impaired sensitivity to heat, which could be a contraindication to aquatics in a heated pool.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE, CHAPTER 6, PAIN, SUFFERING & RESTORATION OF FUNCTION, PG 106** - Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self-actualization.  
**CHAPTER 12, LOW BACK COMPLAINTS, TABLE 12-5:**

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**Physical Therapeutic Interventions**

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Adjustment or modification of workstation, job tasks, or work hours and methods  
Stretching  
Specific low back exercises for range of motion and strengthening  
At-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold  
Relaxation techniques  
Aerobic exercise  
1-2 visits for education, counseling, and evaluation of home exercise for range of motion and strengthening

- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES,**

## **LOW BACK, ACUTE & CHRONIC, EXERCISE RECOMMENDED –**

There is strong evidence that exercise reduces disability duration in employees with low back pain. In acute back pain, exercise therapy may be effective, whereas in subacute back pain, exercises with a graded activity program, and in chronic back pain, intensive exercising, should be recommended. Exercise programs aimed at improving general endurance (aerobic fitness) and muscular strength (especially of the back and abdomen) have been shown to benefit patients with acute low back problems. So far, it appears that the key to success in the treatment of LBP is physical activity in any form, rather than through any specific activity. One of the problems with exercise, however, is that it is seldom defined in various research studies and its efficacy is seldom reported in any change in status, other than subjective complaints. If exercise is prescribed a therapeutic tool, some documentation of progress should be expected. While a home exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision. ([van Tulder-Cochrane, 2000](#)) ([van Tulder, 2000](#)) ([McLain, 1999](#)) ([Philadelphia Panel, 2001](#)) ([Mannion, 2001](#)) ([Burns, 2001](#)) ([Linton, 2001](#)) ([Pengel, 2002](#)) ([Schonstein, 2003](#)) ([Storheim, 2003](#)) ([Keller, 2004](#)) ([Staal, 2004](#)) ([Tveito, 2004](#)) ([Kool, 2004](#)) ([Liddle, 2004](#)) ([Oleske, 2004](#)) ([Rainville, 2004](#)) ([van Poppel, 2004](#)) ([Maher, 2004](#)) ([Koes, 2004](#)) ([Hurwitz, 2005](#)) ([Bruce, 2005](#)) ([Wright, 2005](#)) ([Mayer, 2005](#)) One recent trial found that the best exercise program required that patients continue therapeutic activities even if their pain increased, as opposed to stopping activities due to pain, which supports the hypothesis that fear of pain may be more disabling than pain itself. When pain intensity is used to determine the intensity of the exercises, it may lead to restrictive recommendations regarding activity and work, and it seems to increase behaviors such as taking pain-killers, seeking health care, stopping work, limping, guarding, and talking about pain. ([Kool, 2005](#))

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES**

**AMERICAN PHYSICAL THERAPY ASSOCIATION GUIDELINES FOR AQUATIC THERAPY read “An individual selected for aquatic therapy must be unable to safely participate in a physical therapy program that is totally land-based due to weight bearing restrictions, severe weakness or other considerations”.**